



Appendix C:

DoD Enrollment Forms

INSTRUCTIONS FOR COMPLETING DD FORM 2792-1, EXCEPTIONAL FAMILY MEMBER SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY	
<p>The DD Form 2792-1 is completed to identify a family member with special educational/early intervention needs.</p> <p>DEMOGRAPHICS.</p> <p>Items 1 - 7 (Completed by sponsor or spouse).</p> <p>Item 1.a. Application Status (X one). Initial Screening/Enrollment - First Exceptional Family Member (EFM) application for the family member noted. Updated Information - Update to a previous EFM evaluation for the family member noted. Request Disenrollment - Used to disenroll a child when he/she no longer requires special education or early intervention services, or when the child no longer qualifies as a dependent.</p> <p>Item 1.b. Family Status. Place an "X" in the box if there are any other family members who have been identified as EFMs.</p> <p>Items 2.a. - k. All items refer to sponsor. Self-explanatory.</p> <p>Item 3. <u>Answer Yes</u> if the sponsor was assigned to current duty station for compassionate reasons, e.g., to ensure that a family member receives health care at a major medical treatment facility. <u>Answer No</u> if the sponsor is not currently assigned for compassionate reasons.</p> <p>Item 4. <u>Answer Yes</u> if both spouses are on active duty; otherwise <u>answer No</u>. If <u>Yes</u>, complete Items 4.a. - c.</p> <p>Item 5.a. Exceptional family member name. Enter name for the family member for whom this form will be completed.</p> <p>Item 5.b. Relationship to sponsor. (Son, daughter, etc.)</p> <p>Item 5.c. Date of birth. Self-explanatory.</p> <p>Item 6. Self-explanatory.</p> <p>Item 7. Is family member enrolled in DEERS? Military only. Self-explanatory.</p>	<p>SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY</p> <p>DD Form 2792-1 is completed by the parents and school or early intervention staff. Only this form should be provided to school or early intervention staff. Do not include medical information forms that may be used for EFMP screening or enrollment.</p> <p>Items 1 and 2 are completed by parents. The remainder of this form is completed by school or early intervention staff.</p> <p>Item 1.a. Release of information. Sponsor name. Self-explanatory. Completed by sponsor, spouse, or student who has reached the age of majority.</p> <p>Item 1.b. Rank. Enter the sponsor's rank.</p> <p>Item 1.c. Sponsor SSN. Enter the sponsor's social security number.</p> <p>Item 1.d. Signature of sponsor, spouse, or student who has reached the age of majority. Self-explanatory. Sign and date before providing form to school or early intervention program.</p> <p>Item 1.e. Date signed. Self-explanatory.</p> <p>Items 2.a. - e. Child information. Self-explanatory. Completed by sponsor or spouse.</p> <p>Items 3.a. - e. EIP/School information. Completed by EIP or school personnel. Mark (X) Yes or No for each item. If Yes is marked in Items 3.b. or c., remainder of form must be completed.</p> <p>Items 4.a. - b. Eligibility criteria. Mark only one. (Codes in 4.a. are for Army coding only.)</p> <p>Item 4.c. Identify the disability, if known. (For example, blindness, autism, PDD.)</p> <p>Item 5. Severity. Mark only one.</p> <p>Item 6. Provider/school official information. Self-explanatory.</p>

**EXCEPTIONAL FAMILY MEMBER
SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY**

(Page 1 completed by service member or civilian employee.)
(Read Instructions before completing this form.)

Form Approved
OMB No. 0704-0411
Expires Sep 30, 2006

The public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0411). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): To obtain information needed to evaluate and document the special education needs of: (1) Family members of all service members and (2) Family members of civilian employees processing for an assignment to a location outside the United States where family member travel is authorized at Government expense.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude identification of educational needs and the successful processing of an application for family travel/command sponsorship. Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

DEMOGRAPHICS

1.a. APPLICATION STATUS (X one)				b. FAMILY STATUS	
<input type="checkbox"/> INITIAL SCREENING/ ENROLLMENT	<input type="checkbox"/> UPDATED INFORMATION	<input type="checkbox"/> REQUEST DISENROLLMENT	<input type="checkbox"/> ADDITIONAL FAMILY MEMBERS IDENTIFIED WITH SPECIAL NEEDS		
2. IDENTIFICATION					
a. SPONSOR NAME (Last, First, Middle Initial)		b. SSN		c. RANK OR GRADE	
d. BRANCH OF SERVICE (Military only)		e. DESIG/NEC/MOS/AFSC (Military only)			
f. HOME ADDRESS (Street, Apartment Number, City, State, ZIP Code)		g. DUTY STATION ADDRESS			
		h. E-MAIL ADDRESS			
i. HOME TELEPHONE NUMBER (Include Area Code)		j. FAX NUMBER (Include Area Code)		k. DUTY TELEPHONE NUMBER (Include Area Code)	
				(1) COMMERCIAL (2) DSN	
3. ARE YOU CURRENTLY ON COMPASSIONATE OR HUMANITARIAN ASSIGNMENT? (Military only) (X one)				<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. ARE BOTH SPOUSES ON ACTIVE DUTY? (X one. If Yes, answer a., b., and c. below)				<input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> N/A
a. SPOUSE'S NAME (Last, First, Middle Initial)		b. RANK/RATE		c. SSN	
5.a. EXCEPTIONAL FAMILY MEMBER NAME (Last, First, Middle Initial)		b. RELATIONSHIP TO SPONSOR		c. DATE OF BIRTH (YYYYMMDD)	
6. DOES FAMILY MEMBER RESIDE WITH SPONSOR (X one)					
<input type="checkbox"/> YES					
<input type="checkbox"/> NO IF NO, PROVIDE ADDRESS OF FAMILY MEMBER (Include ZIP Code) AND EXPLAIN WHY.					
7. IS FAMILY MEMBER ENROLLED IN DEERS (Military only) (X one)					
<input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, UNDER WHAT SSN: _____ FAMILY MEMBER PREFIX _____					

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SPECIAL EDUCATION/EARLY INTERVENTION SUMMARY									
NOTE TO PERSONNEL COMPLETING THIS FORM: It is important to the military and to the family that the family be assigned to a location that can meet the child's educational needs. Please take care in completing the requested information. <i>(Attach a copy of the child's most recent active Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) to this page.)</i>									
1. RELEASE OF INFORMATION <i>(To be completed by sponsor, spouse, or student who has reached the age of majority)</i> I hereby authorize the release of information on the DD Form 2792-1 and in the attached reports to personnel of the Military Departments. This information will be used only to evaluate and document my family member's need for early intervention or special education services for the purpose of assignment/coordination of my next assignment.									
a. NAME OF SPONSOR			b. RANK		c. SSN		d. SIGNATURE OF SPONSOR, SPOUSE, OR STUDENT WHO HAS REACHED THE AGE OF MAJORITY		e. DATE (YYYYMMDD)
2. DEPENDENT CHILD INFORMATION <i>(To be completed by sponsor or spouse)</i>									
a. NAME OF CHILD <i>(Last, First, Middle Initial)</i>			b. CURRENT GRADE LEVEL <i>(If school age)</i>		c. DATE OF BIRTH (YYYYMMDD)		d. AGE <i>(Years/months)</i>		e. SEX <i>(X one)</i>
									MALE
									FEMALE
3. EARLY INTERVENTION PROGRAM (EIP)/SCHOOL INFORMATION <i>(To be completed by representative of EIP or school)</i>									
YES		NO		a. IS THE CHILD CURRENTLY BEING EVALUATED FOR SPECIAL EDUCATION OR EARLY INTERVENTION SERVICES?					
				b. DOES THIS CHILD RECEIVE EARLY INTERVENTION SERVICES UNDER A CURRENT INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IFSP.					
				c. DOES THIS CHILD RECEIVE SPECIAL EDUCATION SERVICES UNDER A CURRENT INDIVIDUALIZED EDUCATION PROGRAM (IEP)? IF YES, DATE OF NEXT ANNUAL REVIEW: ATTACH CURRENT IEP.					
				d. IS THE CHILD RECEIVING SERVICES UNDER A SECTION 504 PLAN?					
				e. IS THE CHILD BEING "HOME-SCHOOLED"? IF YES, SPECIFY PROGRAM, IF KNOWN:					
IF YOU ANSWERED "YES" to questions 3.b. or 3.c., complete Items 4, 5, and 6. Sign and return to sponsor. IF YOU ANSWERED "NO" to questions 3.a. through d., DO NOT complete Items 4 and 5, but complete Section 6. Sign and return to sponsor.									
4. ELIGIBILITY CRITERIA <i>(Indicate the eligibility criteria under which the child is eligible for Early Intervention or Special Education.)</i>									
a. IF THE CHILD IS FROM 3 TO 21 YEARS OF AGE:									
<input type="checkbox"/> N07 AUTISTIC		<input type="checkbox"/> N09 COMMUNICATION IMPAIRED		<input type="checkbox"/> N04 MENTAL RETARDATION					
<input type="checkbox"/> N01 DEAF		<input type="checkbox"/> ARTICULATION		<input type="checkbox"/> MILD/MODERATE					
<input type="checkbox"/> N02 BLIND		<input type="checkbox"/> DYSFLUENCY		<input type="checkbox"/> MODERATE/SEVERE					
<input type="checkbox"/> N13 DEAF/BLIND		<input type="checkbox"/> VOICE		<input type="checkbox"/> SEVERE/PROFOUND					
<input type="checkbox"/> N11 VISUALLY IMPAIRED		<input type="checkbox"/> LANGUAGE/PHONOLOGY		<input type="checkbox"/> N12 SPECIFIC LEARNING DISABILITY					
<input type="checkbox"/> N03 HEARING IMPAIRED		<input type="checkbox"/> N05 TRAUMATIC BRAIN INJURY		<input type="checkbox"/> N10 EMOTIONALLY IMPAIRED					
<input type="checkbox"/> N14 PERVASIVE DEVELOPMENTAL DISORDER		<input type="checkbox"/> N06 ORTHOPEDICALLY IMPAIRED		<input type="checkbox"/> N16 BEHAVIORAL/CONDUCT DISORDER					
<input type="checkbox"/> N15 DEVELOPMENTAL DELAY									
N08 OTHER HEALTH IMPAIRED <i>(Specify)</i>									
b. IF THE CHILD IS FROM BIRTH TO 3 YEARS OLD:									
<input type="checkbox"/> DEVELOPMENTAL DELAY				<input type="checkbox"/> HIGH PROBABILITY FOR DEVELOPMENTAL DELAY				c. DISABILITY <i>(Identify if known, e.g., blindness)</i>	
5. SEVERITY OF THE DISABILITY									
<input type="checkbox"/> MILD		<input type="checkbox"/> MODERATE		<input type="checkbox"/> SEVERE		<input type="checkbox"/> PROFOUND			
6. PROVIDER/SCHOOL OFFICIAL INFORMATION									
a. NAME OF INDIVIDUAL COMPLETING THIS SECTION <i>(Last Name, First Name)</i>				b. TITLE		c. TELEPHONE NUMBER <i>(Include area code)</i>		d. FAX NUMBER <i>(Include area code)</i>	
e. NAME OF SCHOOL/EARLY INTERVENTION PROGRAM					f. ADDRESS <i>(Include ZIP Code)</i>				
g. SCHOOL DISTRICT									
h. E-MAIL ADDRESS					i. SIGNATURE			j. DATE SIGNED (YYYYMMDD)	

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**INSTRUCTIONS FOR COMPLETING DD FORM 2792,
EXCEPTIONAL FAMILY MEMBER MEDICAL SUMMARY**

GENERAL.

The DD Form 2792 and attached addenda are completed to identify a family member with special medical needs.

The addenda to the medical summary are completed only if noted in Item 9 of the Demographics/Certification section. The EFM Screening Coordinator and sponsor sign Items 10a and 10b only after all addenda have been completed and the form reviewed for completeness and accuracy.

AUTHORIZATION FOR DISCLOSURE (Page 1).

Health Insurance Portability and Accountability Act (HIPAA) Requirement.

The spouse must sign for the release of his/her own medical information. The sponsor or spouse cannot authorize the release of information for those dependent family members who have reached the age of majority. Please consult with your military treatment facility (MTF) or dental treatment facility (DTF) privacy/HIPAA coordinator about questions regarding authorizations for disclosure.

DEMOGRAPHICS/CERTIFICATION (Page 2).

Items 1 - 8 (Completed by Sponsor or Spouse).

Item 1.a. Application Status (X one).
Initial Screening/Enrollment - First Exceptional Family Member (EFM) application for the family member noted.

Updated Information - Update to a previous EFM evaluation for the family member noted.
Request Disenrollment - Used to disenroll an EFM when he/she no longer has the medical condition that required enrollment, or when the EFM no longer qualifies as a dependent.

Item 1.b. Family Status. Additional Family Member - X if there is another family member who has been identified as an EFM.

Items 2.a. - k. All items refer to sponsor.
Self-explanatory.

Item 3. Answer Yes if the sponsor was assigned to current duty station for humanitarian or compassionate reasons, e.g., to ensure that a family member receives health care at a major medical treatment facility.
Enter No if the sponsor is not currently assigned for humanitarian or compassionate reasons.

Item 4. Answer Yes if both spouses are on active duty; otherwise answer No.

If Yes, complete Items 4.a. - c. (Self-explanatory.)

Item 5.a. Exceptional family member name. Enter name for the family member for whom this form will be completed.

Item 5.b. Relationship to sponsor. (Son, daughter, spouse, etc.)

Item 5.c. Date of birth. Self-explanatory.

Item 6. Primary health care system.

Military treatment facility - services provided by a uniformed or civilian provider at the military treatment facility.

TRICARE/Non-MTF - if the provider is a civilian contract provider who provides services under one of the TRICARE options.

State - if the services are provided under Medicaid or another state program.

Other - if the sponsor is civilian.

Item 7. DEERS enrollment. Military only.
Self-explanatory.

Item 8. Self-explanatory.

Item 9. Required addenda. (Completed by provider and/or EFMP Screening Coordinator.) Mark (X) those addenda that require completion based on a review of medical records and/or screening of a family member. If the addenda are not required, place an X in the box at the upper right hand corner on each addendum indicating that the form is not applicable.

Item 10.a. Sponsor name, signature, date. **Sponsor must ensure that all forms are complete and attached before signing.** In the event that the sponsor is deployed or otherwise unavailable, the spouse may sign the certification.

Item 10.b. EFM Screening Coordinator name, signature, date. **Coordinator must ensure that all forms are complete and attached before signing.**

INSTRUCTIONS FOR COMPLETING DD FORM 2792 (Continued)

MEDICAL SUMMARY.

Sponsor must sign release authorization before Summary is completed.

Items 1.a. - b. Provider name, address, telephone numbers, and fax number. Self-explanatory.

Items 2.a. - b. Provider address and e-mail address. Self-explanatory.

Item 3.a. Diagnoses. Enter the diagnosis(es), one per line.

Item 3.b. Severity. Enter severity of the diagnosis(es).

Item 3.c. ICD or DSM. Enter ICD-9-CM or DSM IV designations.

Item 3.d. Medications and therapies. Self-explanatory.

Item 3.e. Enter the number of visits, hospitalizations, etc., for the last 12 months.

Items 4 - 9. Self-explanatory. Codes in Items 6 and 9 are used by the Army coding teams and should be ignored by persons completing the form.

Item 10. Comments. Enter any additional information to describe this individual's medical needs.

Item 11. (1) Minimum health care specialty. Ignore the codes in the first column under Item 11.a. (used by Army coding teams only). Indicate with an X those specialists required by the patient.

(2) Frequency of care. Enter A - Annually; B - Biannually; Q - Quarterly; M - Monthly; or W - Weekly for each specialist indicated.

Item 12. Name and signature of the provider completing this summary, and date the summary was signed.

ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a. - c. Self-explanatory.

Items 2.a.- c. Self-explanatory.

Items 3.a.- e. Self-explanatory.

Items 4 - 6. Self-explanatory.

ADDENDUM 2 - MENTAL HEALTH SUMMARY.

This addendum is completed only if indicated in Item 9, Demographics/Certification.

Items 1.a.-c. Self-explanatory.

Items 2.a.-c. - 5.a.-b. Self-explanatory.

Item 6. Cooperation. Describe patient (guardian if a minor) cooperation with treatment.

Items 7 - 8. Self-explanatory.

Item 9. Comments. Include any additional information that would assist in determining necessary treatment.

EXCEPTIONAL FAMILY MEMBER MEDICAL SUMMARY*(To be completed by service member or civilian employee.)**(Read Instructions before completing this form.)**Form Approved**OMB No. 0704-0411**Expires Sep 30, 2006*

The public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0704-0411). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.**PRIVACY ACT STATEMENT****AUTHORITY:** 10 USC 3013, 5013, and 8013; 20 USC 921 - 932; and EO 9397.

PRINCIPAL PURPOSE(S): Information will only be used by personnel of the Military Departments to evaluate and document the medical needs of family members. This information will enable: (1) Military assignment personnel to match the needs of family members against the availability of medical services; and (2) Civilian personnel offices to determine the availability of medical services to meet the medical needs of family members of DoD and Military Department civilian employees.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary for civilian employees and applicants for civilian employment; failure to respond will preclude the successful processing of an application for family travel/command sponsorship.

Mandatory for military personnel; failure or refusal to provide the information or providing false information may result in administrative sanctions or punishment under either Article 92 (dereliction of duty) or Article 107 (false official statement), Uniform Code of Military Justice.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Authority - Public Law 104-191, "Health Insurance Portability and Accountability Act (HIPAA)", August 21, 1996.

This form will not be used for authorization to disclose psychotherapy notes, alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program.

I authorize _____ (MTF/DTF) to release my patient information to the Exceptional Family Member/Special Needs Program to be used in the assignment coordination process. The information on this form and addenda will be used to determine whether there are adequate medical, housing and community resources to meet your special medical needs at the sponsor's proposed duty locations.

a. The military medical department will use the information to make recommendations on the availability of care in communities where the sponsor may be assigned or employed.

b. Information that you have a special need (not the nature or scope of the need) may be included in the sponsor's personnel record or be maintained in the community office responsible for supporting families with special needs.

c. The authorization applies to the summary data included on the medical summary form, its addenda and subsequent updates to information on this form. These data may be stored in electronic databases used for medical management or dedicated to the assignment coordination process. Only representatives from the medical department and the offices responsible for EFMP assignment coordination will have access to the information.

Start Date: The authorization start date is the date that you sign this form authorizing the release of information.

Expiration Date: The authorization shall continue until enrollment in the Exceptional Family Member Program/Special Needs Program is no longer necessary according to Service specific criteria, or you no longer meet the criteria to qualify as a dependent, or the sponsor is no longer in active military service or employment of the U.S. Government overseas.

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524. I request and authorize the named provider/treatment facility to release the information described above to the named individual/organization indicated.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

SIGNATURE OF PATIENT/PARENT/GUARDIAN**RELATIONSHIP TO PATIENT** *(If applicable)***DATE** (YYYYMMDD)**DD FORM 2792, SEP 2003**

PREVIOUS EDITION IS OBSOLETE.

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DEMOGRAPHICS/CERTIFICATION									
1.a. APPLICATION STATUS <i>(X one)</i>						b. FAMILY STATUS			
<input type="checkbox"/>	INITIAL SCREENING/ ENROLLMENT	<input type="checkbox"/>	UPDATED INFORMATION	<input type="checkbox"/>	REQUEST DISENROLLMENT	<input type="checkbox"/> ADDITIONAL FAMILY MEMBER HAS BEEN IDENTIFIED			
2.a. SPONSOR NAME <i>(Last, First, Middle Initial)</i>						b. SSN		c. RANK OR GRADE	
d. BRANCH OF SERVICE <i>(Military only)</i>						e. DESIG/NEC/MOS/AFSC <i>(Military only)</i>			
f. HOME ADDRESS <i>(Street, Apartment Number, City, State, ZIP Code)</i>						g. DUTY STATION ADDRESS			
						h. E-MAIL ADDRESS			
i. HOME TELEPHONE NUMBER <i>(Include Area Code)</i>			j. FAX NUMBER <i>(Include Area Code)</i>		k. DUTY TELEPHONE NUMBER <i>(Include Area Code)</i> (1) COMMERCIAL		(2) DSN		
3. ARE YOU CURRENTLY ON COMPASSIONATE OR HUMANITARIAN ASSIGNMENT? <i>(Military only) (X one)</i>						<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
4. ARE BOTH SPOUSES ON ACTIVE DUTY? <i>(X one. If Yes, answer a., b., and c. below)</i>						<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
a. SPOUSE'S NAME <i>(Last, First, Middle Initial)</i>						b. RANK/RATE		c. SSN	
5.a. EXCEPTIONAL FAMILY MEMBER NAME <i>(Last, First, Middle Initial)</i>						b. RELATIONSHIP TO SPONSOR		c. DATE OF BIRTH (YYYYMMDD)	
6. PRIMARY HEALTH CARE SYSTEM USED BY FM <i>(X one)</i>						7. IS FAMILY MEMBER ENROLLED IN DEERS <i>(Military only) (X one)</i>			
<input type="checkbox"/> MILITARY TREATMENT FACILITY		<input type="checkbox"/> STATE		<input type="checkbox"/> YES		IF YES, UNDER WHAT SSN: _____			
<input type="checkbox"/> TRICARE/NON-MTF		<input type="checkbox"/> OTHER		<input type="checkbox"/> NO		FAMILY MEMBER PREFIX _____			
8. DOES FAMILY MEMBER RESIDE WITH SPONSOR <i>(X one)</i>									
<input type="checkbox"/> YES									
<input type="checkbox"/> NO. IF NO, PROVIDE ADDRESS OF FAMILY MEMBER <i>(Include ZIP Code)</i> AND EXPLAIN WHY.									
9. REQUIRED ADDENDA <i>(X as necessary)</i>									
<input type="checkbox"/> ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY									
<input type="checkbox"/> ADDENDUM 2 - MENTAL HEALTH SUMMARY									
10. CERTIFICATION									
We certify that the information submitted on this DD Form 2792 (Medical Summary and the addenda checked above) are complete and accurate.									
a. SPONSOR <i>(See Instructions)</i>									
(1) PRINTED NAME					(2) SIGNATURE			(3) DATE (YYYYMMDD)	
b. EFMP SCREENING COORDINATOR									
(1) PRINTED NAME					(2) SIGNATURE			(3) DATE (YYYYMMDD)	
(4) MILITARY TREATMENT FACILITY ADDRESS <i>(Include ZIP Code)</i>								(5) TELEPHONE NUMBER <i>(Include area code)</i>	

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MEDICAL SUMMARY					
PATIENT NAME			SPONSOR SSN		FAMILY MEMBER PREFIX
PART A - PROVIDER INFORMATION <i>(Authorization by patient included on Page 1 of this form.)</i>					
1.a. PROVIDER NAME			2.a. ADDRESS <i>(Include ZIP Code)</i>		
b. TELEPHONE NUMBERS <i>(Include Area Code)</i>			b. E-MAIL ADDRESS		
(1) COMMERCIAL	(2) DSN	(3) FAX NUMBER			
PART B - PATIENT STATUS <i>(To be completed by provider)</i>					
3. DIAGNOSIS(ES) Please complete as accurately as possible using ICD-9-CM or DSM IV.					
a. CURRENT ACTIVE DIAGNOSIS	b. SEVERITY: A - MILD B - MODERATE C - SEVERE	c. ICD OR DSM	d. MEDICATIONS AND SPECIAL THERAPIES	e. COMPLETE FOR THE LAST 12 MONTHS:	
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
					(1) NUMBER OF OUTPATIENT VISITS
					(2) NUMBER OF ER VISITS
					(3) NUMBER OF HOSPITALIZATIONS
					(4) NUMBER OF ICU ADMISSIONS
4. PROGNOSIS <i>(Include expected length of treatment, required participation of family members, and if treatment is ongoing)</i>					
5. TREATMENT PLAN <i>(Medical, mental health, surgical procedures or therapies planned over the next three years)</i>					
6. ARTIFICIAL OPENINGS/PROSTHETICS <i>(e.g., gastrostomy, tracheostomy, VP shunts, artificial limbs)</i>				CODING USE ONLY	
<input type="checkbox"/> YES IF YES, SPECIFY: <input type="checkbox"/> NO				F01 - GASTROSTOMY F07 - OTHER, UNSPECIFIED PROSTHETICS F02 - TRACHEOSTOMY F03 - CSF SHUNT F04 - CYSTOSTOMY F05 - COLOSTOMY F06 - ILEOSTOMY F99 - OTHER UNSPECIFIED OPENING	

MEDICAL SUMMARY (Continued)																
PATIENT NAME	SPONSOR SSN	FAMILY MEMBER PREFIX														
7. HISTORY OF CANCER OR LEUKEMIA <input type="checkbox"/> YES IF YES, SPECIFY PROJECTED TREATMENT NEEDS: <input type="checkbox"/> NO																
8. ENVIRONMENTAL/ARCHITECTURAL CONSIDERATIONS (e.g., limited steps, complete wheelchair accessibility, air conditioning) <input type="checkbox"/> YES IF YES, SPECIFY: <input type="checkbox"/> NO																
9. ADAPTIVE EQUIPMENT/SPECIAL MEDICAL EQUIPMENT (X as applicable) <table border="1"><tr><td><input type="checkbox"/> L03 - APNEA HOME MONITOR</td><td><input type="checkbox"/> L99 - OTHER (Specify)</td></tr><tr><td><input type="checkbox"/> L13 - HOME NEBULIZER</td><td></td></tr><tr><td><input type="checkbox"/> L08 - WHEELCHAIR</td><td></td></tr><tr><td><input type="checkbox"/> L07 - SPLINTS, BRACES, ORTHOTICS</td><td></td></tr><tr><td><input type="checkbox"/> L04 - HEARING AIDS</td><td></td></tr><tr><td><input type="checkbox"/> L12 - HOME OXYGEN THERAPY</td><td></td></tr><tr><td><input type="checkbox"/> L14 - HOME VENTILATOR</td><td></td></tr></table>			<input type="checkbox"/> L03 - APNEA HOME MONITOR	<input type="checkbox"/> L99 - OTHER (Specify)	<input type="checkbox"/> L13 - HOME NEBULIZER		<input type="checkbox"/> L08 - WHEELCHAIR		<input type="checkbox"/> L07 - SPLINTS, BRACES, ORTHOTICS		<input type="checkbox"/> L04 - HEARING AIDS		<input type="checkbox"/> L12 - HOME OXYGEN THERAPY		<input type="checkbox"/> L14 - HOME VENTILATOR	
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<input type="checkbox"/> L04 - HEARING AIDS																
<input type="checkbox"/> L12 - HOME OXYGEN THERAPY																
<input type="checkbox"/> L14 - HOME VENTILATOR																
10. COMMENTS (Enter additional information to describe this individual's medical needs.)																

MEDICAL SUMMARY <i>(Continued)</i>						
PATIENT NAME			SPONSOR SSN		FAMILY MEMBER PREFIX	
PART C - REQUIRED CARE <i>(To be completed by provider)</i>						
11. MINIMUM HEALTH CARE SPECIALTY REQUIRED FOR CARE						
INDICATE THE FREQUENCY OF CARE: A - ANNUALLY B - BIANNUALLY Q - QUARTERLY M - MONTHLY W - WEEKLY						
(1) CARE PROVIDER <i>(X as appropriate)</i>			(2) FREQUENCY	(1) CARE PROVIDER <i>(X as appropriate)</i>		
C01	a.	ALLERGIST		C57	ee.	PAIN CLINIC
C52	b.	AUDIOLOGIST		C30	ff.	PEDIATRICIAN
C02	c.	CARDIOLOGIST		C31	gg.	PEDODONTIST
C03	d.	CARDIOLOGIST - PEDIATRIC		C32	hh.	PHYSIATRIST
C05	e.	DERMATOLOGIST		C58	ii.	PHYSICAL THERAPIST
C06	f.	DEVELOPMENTAL PEDIATRICIAN		C59	jj.	PHYSICAL THERAPIST - PEDIATRIC
C53	g.	DIALYSIS TEAM		C34	kk.	PODIATRIST
C07	h.	DIETARY/NUTRITION SPECIALIST		C35	ll.	PSYCHIATRIST
C08	i.	ENDOCRINOLOGIST - ADULT		C36	mm.	PSYCHIATRIST - CHILD
C09	j.	ENDOCRINOLOGIST - PEDIATRIC		C37	nn.	PSYCHOLOGIST
C10	k.	FAMILY PRACTITIONER		C38	oo.	PSYCHOLOGIST - CHILD
C11	l.	GASTROENTEROLOGIST - ADULT		C33	pp.	PULMONOLOGIST
C12	m.	GASTROENTEROLOGIST - PEDIATRIC		C60	qq.	RESPIRATORY THERAPIST
C13	n.	GENERAL MEDICAL OFFICER		C39	rr.	RHEUMATOLOGIST
C15	o.	GYNECOLOGIST		C40	ss.	RHEUMATOLOGIST - PEDIATRIC
C17	p.	HEMATOLOGIST/ONCOLOGIST		C61	tt.	SOCIAL WORKER
C18	q.	HEMATOLOGIST/ONCOLOGIST - PEDIATRIC		C62	uu.	SPEECH AND LANGUAGE PATHOLOGIST
C19	r.	IMMUNOLOGIST		C42	vv.	SURGEON - CARDIAC/THORACIC
C20	s.	INTERNIST		C43	ww.	SURGEON - GENERAL
C21	t.	NEPHROLOGIST - ADULT		C44	xx.	SURGEON - NEURO
C22	u.	NEPHROLOGIST - PEDIATRIC		C45	yy.	SURGEON - ORAL
C23	v.	NEUROLOGIST - ADULT		C47	zz.	SURGEON - ORTHOPEDIC - ADULT
C24	w.	NEUROLOGIST - PEDIATRIC		C48	aaa.	SURGEON - ORTHOPEDIC - CHILD
C25	x.	NUCLEAR MEDICAL PHYSICIAN		C46	bbb.	SURGEON - OTORHINOLARYNGOLOGIST
C54	y.	OCCUPATIONAL THERAPIST		C49	ccc.	SURGEON - PEDIATRIC
C55	z.	OCCUPATIONAL THERAPIST - PEDIATRIC		C50	ddd.	SURGEON - PLASTIC
C26	aa.	OPHTHALMOLOGIST		C41	eee.	TRANSPLANT TEAM
C27	bb.	OPHTHALMOLOGIST - PEDIATRIC		C51	fff.	UROLOGIST
C29	cc.	ORTHODONTIST		C99	ggg.	OTHER <i>(Describe)</i>
C56	dd.	OTORHINOLARYNGOLOGIST				
12.a. PROVIDER NAME			b. SIGNATURE			c. DATE (YYYYMMDD)

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ADDENDUM 1 - ASTHMA/REACTIVE AIRWAY DISEASE SUMMARY <i>(To be completed by provider)</i>								<input type="checkbox"/> X IF NOT APPLICABLE
1.a. PATIENT NAME				b. SPONSOR SSN		c. FAMILY MEMBER PREFIX		
2.a. PROVIDER NAME <i>(PCM or specialty provider)</i>				b. SIGNATURE			c. DATE (YYYYMMDD)	
3. MEDICATION HISTORY								
a. PAST	b. PRESENT	c. MEDICATION			d. DOSAGE		e. FREQUENCY	
4. HISTORY ASSOCIATED WITH ASTHMA ATTACKS <i>(X as applicable)</i>								
YES	NO	a. ARE THERE ANY TRIGGERS FOR THE FAMILY MEMBER'S ASTHMA ATTACKS <i>(stress, environmental, exercise)?</i>						
		b. DOES THE FAMILY MEMBER ROUTINELY <i>(greater than 10 days per month/four months per year)</i> USE INHALED ANTI-INFLAMMATORY AGENTS AND/OR BRONCHODILATORS?						
		c. HAS THE FAMILY MEMBER TAKEN ORAL STEROIDS DURING THE PAST YEAR <i>(prednisone, prednisolone)?</i> IF YES, NUMBER OF DAYS IN PAST YEAR:						
		d. HAS THE FAMILY MEMBER EVER EXPERIENCED UNCONSCIOUSNESS OR SEIZURES ASSOCIATED WITH ASTHMA ATTACKS?						
		e. HAS THE FAMILY MEMBER REQUIRED AN URGENT VISIT TO THE ER OR CLINIC FOR ACUTE ASTHMA DURING THE PAST YEAR? IF "YES", INDICATE THE NUMBER OF VISITS IN THE PAST YEAR:						
		f. HAS THE FAMILY MEMBER BEEN HOSPITALIZED FOR PULMONARY DISEASE <i>(pneumonia, bronchitis, bronchiolitis, croup, RSV)</i> DURING THE PAST YEAR? IF "YES", INDICATE THE DATE(S) OF HOSPITALIZATION (YYYYMMDD):						
		g. DOES THE FAMILY MEMBER HAVE A HISTORY OF ONE OR MORE HOSPITALIZATIONS FOR ASTHMA RELATED CONDITIONS WITHIN THE PAST 5 YEARS? IF "YES", HOW MANY? INDICATE DATE OF LAST ADMISSION (YYYYMMDD):						
		h. HAS THE FAMILY MEMBER REQUIRED MECHANICAL VENTILATION <i>(Intubation/use of respirator)</i> DURING THE PAST 3 YEARS?						
		i. DOES THE FAMILY MEMBER HAVE A HISTORY OF INTENSIVE CARE ADMISSIONS?						
j. HOW MANY DAYS HAS THE FAMILY MEMBER MISSED SCHOOL/WORK/PLAY DUE TO ASTHMA-RELATED PROBLEMS <i>(including visits to physicians)</i> DURING THE PAST YEAR?								
5. DISRUPTION OF ACTIVITY. How often does asthma disrupt the following activities? <i>(X as applicable)</i>								
(1) ACTIVITY		(2) NEVER A PROBLEM	(3) 2 TIMES A YEAR OR LESS	(4) 3 - 7 TIMES A YEAR	(5) 8 - 10 TIMES A YEAR	(6) AT LEAST MONTHLY	(7) AT LEAST WEEKLY	(8) ALMOST DAILY
a. SLEEP								
b. QUIET ACTIVITY								
c. SOCIALIZATION WITH FRIENDS								
d. SCHOOL OR WORK ATTENDANCE								
e. OUTDOOR ACTIVITIES								
f. VIGOROUS/PLAY ACTIVITIES								
6. SEVERITY LEVEL. What is the family member's severity level based on the clinical picture? <i>(Select one level of severity. Definitions are examples of severity. Pulmonary function tests are required only if clinically indicated.)</i>								
a. INTERMITTENT ASTHMA. Intermittent symptoms \leq 1 time per week. Brief exacerbations (from a few hours to a few days). Nighttime asthma symptoms $<$ 2 times a month. Asymptomatic and normal lung function between exacerbations. PEF or FEV1 \geq 80% predicted; variability $<$ 20%.								
b. MILD PERSISTENT ASTHMA. Symptoms \geq 2 times a week but $<$ 1 time per day. Exacerbations may affect sleep and activity. Nighttime asthma symptoms $>$ 2 times a month. PEF or FEV1 \geq 80% predicted; variability 20 - 30%.								
c. MODERATE PERSISTENT. Symptoms daily. Exacerbations affect sleep and activity. Nighttime asthma $>$ 1 time a week. Daily use of inhaled short-acting B2 agonist. PEF or FEV1 \geq 60% and 80% predicted; variability $>$ 30%.								
d. SEVERE PERSISTENT. Continuous symptoms. Frequent exacerbations. Frequent nighttime asthma symptoms. Physical activities limited by asthma symptoms. PEF or FEV1 \leq 60% predicted; variability $>$ 30%.								

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ADDENDUM 2 - MENTAL HEALTH SUMMARY <i>(To be completed by provider)</i>					<input type="checkbox"/> X IF NOT APPLICABLE
1.a. PATIENT NAME		b. SPONSOR SSN		c. FAMILY MEMBER PREFIX	
2.a. PROVIDER NAME <i>(PCM or specialty provider)</i>		b. SIGNATURE			c. DATE <i>(YYYYMMDD)</i>
3.a. DIAGNOSIS(ES)					b. AGE AT DIAGNOSIS
4. MEDICATION HISTORY					
a. MEDICATION		b. DOSAGE		c. LENGTH OF TIME ON MEDICATION	d. RESPONSE
5. HISTORY OF MENTAL HEALTH HOSPITALIZATIONS					
(1) TYPE OF STAY		(2) DATES		(3) DISCHARGE DIAGNOSES	
a. HOSPITAL STAYS					
b. PARTIAL-DAY HOSPITALIZATIONS					
6. HOW COOPERATIVE IS/WAS PATIENT WITH TREATMENT? <i>(Parent/legal guardian cooperation, if a minor.)</i>					
7. TREATMENT NEEDS WITHIN THE NEXT YEAR <i>(Consider increased stressors of residing in new environment (e.g., stressors of family relocation, isolated posts, deployments, foreign cultures, restricted travel, separation from nuclear family, cost of living.)</i>					
NO ASSISTANCE REQUIRED		FEWER THAN 4 CONTACTS		4 OR MORE CONTACTS	INPATIENT SERVICES
8. HISTORY					
YES	NO	a. HISTORY OF SUICIDAL GESTURES/ATTEMPTS?			
		b. HISTORY OF SUBSTANCE ABUSE/ADDICTIVE BEHAVIORS/EATING DISORDERS?			
		c. HISTORY OF PROBLEMS WITH AUTHORITY FIGURES?			
		d. HISTORY OF PSYCHOTIC EPISODES?			
		e. HISTORY OF FAMILY ADVOCACY PROGRAM INVOLVEMENT? <i>(If Yes and case occurred in last 18 months, include case determination, treatment and follow-up.)</i>			
9. OTHER COMMENTS <i>(Include additional information that would assist in determining necessary treatments.)</i>					

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